HOUSTON Methodist
THE WOODLANDS HOSPITAL

HOUSTON METHODIST SPECIALTY PHYSICIAN GROUP
INSTITUTE FOR RECONSTRUCTIVE SURGERY
CONSENT AND RELEASE FOR PHOTOS

I hereby agree to be photographed and/or have my image recorded by other means by Houston Methodist Specialty Physician Group ("Physician Group") to assist with my treatment, patient education and for medical records documentation purposes. In addition to these purposes, I hereby authorize and consent to the treating physician and Physician Group using the images for the purpose of (**please initial** the statements that apply):

_____ Medical education (including, but not limited to, conferences, graduate medical education, and continuing medical education)
_____ Medical publications and professional trade organizations (including, but not limited to, the American Board of Plastic Surgery, Inc.)
_____ News, publicity, advertising, marketing (including, but not limited to, print and internet publications)
_____ Office Photo Album

_____ I understand that I shall not be identified by name.

I understand that, during the course of any such interview, photographing, or recording, my health information, including care at this Physician Group (my "Information") will be stored confidential and may be disclosed consistent with the authorizations granted in this consent. I agree to the distribution and publication of the photographs, and other recordings via print or electronic means, including, but not limited to, the treating physician's website, the Physician Group's website, the Physician Group's publications and other permitted uses. I further grant permission for any such photographs to be edited and incorporated into any compilation or derivative work as is deemed necessary or appropriate by the Physician Group. I waive any right to inspect or approve my depictions in these works. In addition, I hereby grant permission for the use of any of my information, for use in examination, testing, credentialing, and/or re-certifying purposes by the American Board of Plastic Surgery, Inc. Please note that once information has been publicly shared on the internet it may appear in search results or be further used or disclosed by third parties without your permission.

I understand that this release and consent is voluntary and that I will receive no compensation for the use and disclosure of my information and likeness for the Group's internal, promotional, and advertising purposes. I further understand that I will have no economic or ownership rights in the interviews, photographs, and other recordings authorized above. I understand that it will be necessary for me to execute Group's "HIPPA AUTHORIZATION FOR PERMITTED USES" in order to allow Group to use my protected health information in connection with this Consent and Release for Photos. I understand that I am not required to sign this Consent and Release for Photos in order to be eligible for treatment or other services from Group. **I UNDERSTAND THAT I MAY REVOKE MY CONSENT AT ANY TIME BY NOTIFING THE MEDICAL GROUP.** I understand that my revocation will not affect any actions Group took pursuant to this Consent and Release for Photos, Media, and Promotional Materials before Group received my revocation.

I hereby release the Physician Group as well as the Group's representatives (including treating physician) and affiliates from any and all claims, liability, and damages that might arise from the use and disclosure of my name, photograph, information, or likeness consistent with the authorization granted herein.

_____ _____
PATIENT PRINTED NAME **DATE**

_____
PATIENT SIGNATURE

Note: A copy of this completed, signed, and dated form must be provided to the patient or patient's representative.